



Appeals and Independent Reviews Your Rights Under the Illinois Managed Care Reform and Patient Rights Act

The Managed Care Reform and Patient Rights Act provides Illinois consumers with more control of their health care by placing stricter requirements on HMOs, insurance companies, doctors, and other health care providers. The Act also gives consumers specific rights, including:

- **THE RIGHT TO APPEAL** service denial decisions made by their health care plan
- **THE RIGHT TO REQUEST AN EXTERNAL INDEPENDENT REVIEW** if an appeal for medical services is denied by their health care plan

The Act generally applies to state regulated managed care plans, including all state regulated HMOs. The Act does not apply to indemnity health insurance policies, plans that offer only dental or vision coverage, Preferred Provider Administrators, ERISA plans, care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act, or not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999, that are affiliated with a union and that only extend coverage to union members and their dependents.

THE RIGHT TO APPEAL

Who can appeal a denial of services by a health care plan?

After any denial of services, an appeal may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider.

How does the appeal process work?

The appeal may be made either orally or in writing. Upon submission of an appeal, the health care plan must notify the party within 3 business days of all the information the health care plan requires to evaluate the appeal.

What is the time frame of the appeals process?

Upon receipt of the required information, the health care plan must make a decision within 15 business days. The health care plan must orally notify the party filing the appeal, the enrollee, the enrollee's primary physician, and any health care provider who recommended the health care service involved in the appeal of its decision, with a written notice of the determination to follow.

What if my appeal qualifies as an expedited review?

Expedited reviews must be provided if a delay would significantly increase the risk to an enrollee's health or when extended services for an ongoing course of treatment are at issue.

What is the time frame for an expedited review?

The appeal can be made either orally or in writing. Upon submission of an appeal, the health care plan must notify the party within 24 hours of all the information the health care plan requires to evaluate the appeal. Upon receipt of the required information, the health care plan must make a decision

within 24 hours and orally notify the party filing the appeal, the enrollee, enrollee's primary physician, and any health care provider who recommended the health care service involved in the appeal of its decision, with a written notice of the determination to follow.

What information must be included in the written notice of decision?

The written notice of determination must include: clear and detailed reasons for the determination; the medical or clinical criteria for the determination, which must be based upon sound clinical evidence and reviewed on a periodic basis; and, in the case of an adverse determination, the procedures for requesting an external independent review.

Once I have exhausted the internal appeals process of my health care plan, do I have any other options?

Yes. If an appeal is denied, any involved party may request an external independent review.

Appeals Process

1. Enrollee/party submits appeal of adverse determination.
2. **Within 3 business days of receipt of appeal**, the health care plan must notify enrollee/party of all information needed to evaluate the appeal.
3. After the health care plan receives all information, it must, **within 15 business days**, render a decision on the appeal and orally notify enrollee/party, primary physician, and any health care provider involved, followed by written notice.

Expedited Appeals Process

(when a delay could significantly increase the risk to enrollee's health)

1. Enrollee/party submits request for expedited appeal.
2. **Within 24 hours of request**, the health care plan must notify enrollee/party of all information needed to evaluate the appeal.
3. After the health care plan receives all information, it must, **within 24 hours**, render a decision on the appeal and orally notify enrollee/party, primary physician, and any health care provider involved, followed by written notice.

THE RIGHT TO REQUEST AN EXTERNAL INDEPENDENT REVIEW

Who can request an external review of a health care plan's decision?

Once an adverse determination is made in the internal appeals process, any involved party has the option to demand an external review by an independent reviewer.

How does the appeals process work?

Notification of demand for an external review must be made in writing within 30 days of the date of receipt of the adverse determination from the internal appeals process. Remember to include all relevant information and documentation to support your request for services.

What is the time frame for the external independent review process?

Within 30 days of receiving a written request, the health care plan must provide for joint selection of an external independent reviewer. This reviewer must be a clinical peer, have no direct financial interest in connection with the case, and be unaware of the identity of the enrollee requesting the review. Your health care plan will give you a list of doctors from which to choose.

How long does the independent reviewer have to make a decision?

Within the same 30 day time frame, the health care plan must forward to the reviewer all medical records and supporting documents, a summary description of the issues, the criteria used in coming to a decision, and the medical reasons for the decision. Upon receipt of all these materials, the external reviewer has 5 days to make a determination of whether or not the claim or service is medically appropriate.

What if my appeal qualifies as an expedited review?

Expedited reviews must be provided when a delay would significantly increase the risk to an enrollee's health or when extended services for an ongoing course of treatment are at issue.

What is the time frame for an expedited review?

Health care plans must make a determination and provide notice of the determination within 24 hours of receipt of all information.

What if I do not agree with the decision made by the independent reviewer? Do I have any other avenues to pursue my dispute?

The decision of the independent reviewer is final. Once your health care plan has completed an external review process, you have exhausted your rights.

What happens if the external independent reviewer decides that the service or claim is medically necessary?

If the independent reviewer determines the services to be medically appropriate, then your health care plan must pay for the services.

Who has to pay for the external independent reviewer?

The health care plan is solely responsible for paying the fees of the external independent reviewer, whether or not the service or claim is determined to be medically appropriate.

External Independent Review Process

1. Enrollee receives written notice of adverse determination from internal appeal.
2. **Within 30 days of receipt of notice**, enrollee must send written request for external independent review.
3. **Within 30 days of receipt of request**, the health care plan should:
 - provide a mechanism for joint selection of an external independent reviewer.
 - forward medical records to the independent reviewer.
4. **Within 5 days of receipt of medical records**, the independent reviewer must render a decision.

Expedited Independent Review Process

(when a delay could significantly increase the risk to enrollee's health)

1. Party seeking an external independent reviewer notifies the health care plan.
2. Health care plan receives all information.
3. **Within 24 hours**, the health care plan must make a decision.

If you believe you were denied services to which you were entitled or require assistance in pursuing your appeal, contact the Illinois Attorney General's Health Care Helpline at 1-877-305- 5145 (TTY: 1-800-964-3013).

Please visit
www.IllinoisAttorneyGeneral.gov



Chicago
1-800-386-5438
TTY: 1-800-964-3013

Springfield
1-800-243-0618
TTY: 877-844-5461

Carbondale
1-800-243-0607
TTY: 877-675-9339